Kevzara® (sarilumab)
Effective January 1, 2021

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefit</th>
<th>Program Type</th>
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<tbody>
<tr>
<td>☐ MassHealth</td>
<td>☑ MassHealth (PUF)</td>
<td>☑ Prior Authorization</td>
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<tr>
<td>☐ MassHealth (PUF)</td>
<td>☑ Commercial/Exchange</td>
<td>☑ Quantity Limit</td>
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<td>☐ Commercial/Exchange</td>
<td>☑ Pharmacy Benefit</td>
<td>☐ Step Therapy</td>
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<tr>
<td>☐ Medical Benefit (NLX)</td>
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Specialty Limitations
This medication has been designated specialty and must be filled at a contracted specialty pharmacy.

Specialty Medications
All Plans   Phone: 866-814-5506   Fax: 866-249-6155

Non-Specialty Medications
MassHealth   Phone: 877-433-7643   Fax: 866-255-7569
Commercial   Phone: 800-294-5979   Fax: 888-836-0730
Exchange     Phone: 855-582-2022   Fax: 855-245-2134

Medical Specialty Medications (NLX)
All Plans   Phone: 844-345-2803   Fax: 844-851-0882

Exceptions
N/A

Overview
Kevzara® (sarilumab) is an interleukin-6 (IL-6) receptor blocker indicated for:
• Treatment of adult patients with moderately to severely active rheumatoid arthritis

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Kevzara, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs

OR
Authorization may be granted if the member meets ALL following criteria and documentation has been submitted:

Moderate to Severe Rheumatoid Arthritis (RA)
Prescriber provides documentation of ALL the following:
• Appropriate diagnosis
• ONE of the following:
  a. Paid claims or physician documented inadequate response or adverse reaction to at least ONE traditional DMARD (See Appendix B) or contraindication to traditional DMARDs
  b. Paid claims or physician documented inadequate response or adverse reaction to ONE biologic DMARD that is FDA-approved for the requested indication
• Dosing is appropriate

Continuation of Therapy
Reauthorization requires physician documentation of continuation of therapy, positive response to therapy, FDA approved indication and appropriate dosing.

Limitations
1. Initial approvals will be for 6 months.
2. Reauthorizations will be for 12 months.
3. The following quantity limits apply:

<table>
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<tr>
<th>Kevzara 150mg/1.14mL</th>
<th>2 syringes/pens per 28 days</th>
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<tbody>
<tr>
<td>Kevzara 200mg/1.14mL</td>
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Appendix A
| Kevzara® (sarilumab) | Rheumatoid arthritis: 200 mg subcutaneously every two weeks, reduce dose to 150 mg for management of neutropenia, thrombocytopenia and elevated liver enzymes |

Appendix B. Conventional Therapies for Plaque Psoriasis

<table>
<thead>
<tr>
<th>Conventional Treatment Lines</th>
<th>Agents Used</th>
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<tbody>
<tr>
<td>Topical Agents</td>
<td>emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors</td>
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<tr>
<td>Systemic Agents</td>
<td>Traditional DMARDs: methotrexate, apremilast, acitretin,</td>
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<tr>
<td>Phototherapy</td>
<td>ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)</td>
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References

Review History
03/01/18 – Effective
02/20/19 – Reviewed in P&T Meeting

Disclaimer
AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.